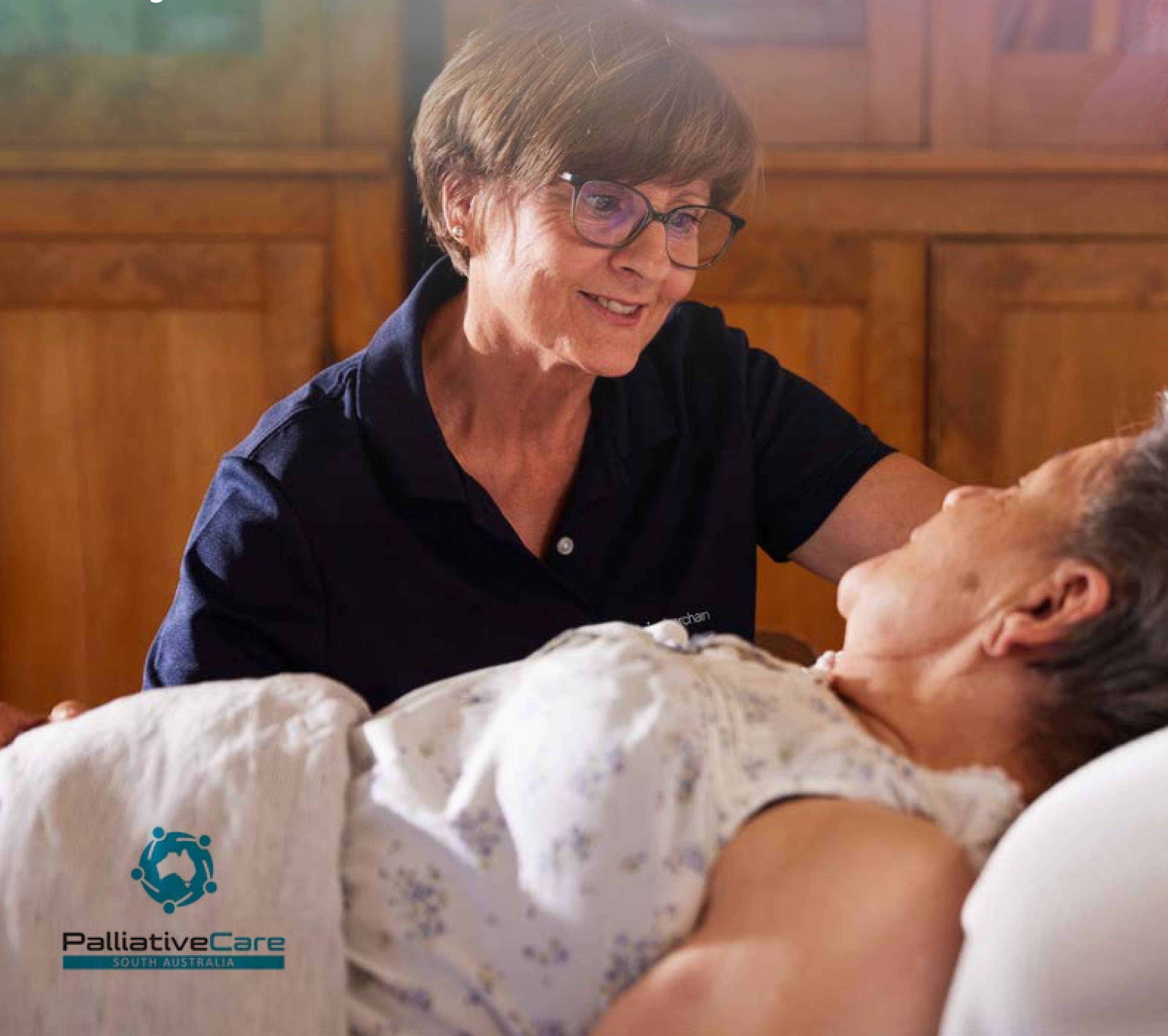
Government of South Australia
SA Health

Palliative Care 2022 Grants Program

Project Showcase



PalliativeCare
SOUTH AUSTRALIA

Contents

Minister's Foreword

The Palliative Care Grants Program provides funding to non-government organisation (NGO) pilot projects striving to improve the experience of South Australians accessing palliative care services and support in the community.

The 2022 program awarded a total of $876,000 across 13 innovative projects aiming to improve and diversify palliative care options that support people facing the immense challenges of a life-limiting illness.

Each article in this showcase captures the achievements of these initiatives and provides a direct perspective from the people involved: the healthcare professionals, volunteers, NGO teams, carers, researchers, community members, patients and their families.

The variety of project settings represented in this grant round demonstrate an exciting expansion in high quality palliative care and support reaching beyond the hospital and hospice, through community groups, primary care services, residential aged care facilities, and into the home.

It is also fantastic to see benefits from projects focussing on our regional areas and populations with specific care and support needs, such as Aboriginal communities and patients with non-malignant diseases.

Whether you are interested in learning about how grant recipients are increasing knowledge through research, expanding access to volunteers, implementing new training for health professionals, or enabling more people to effectively communicate their wishes at end-of- life, I hope that you find inspiration in the stories told through this showcase.

I commend all who have participated in the 2022 Palliative Care Grants Program for their achievements and contributions to a more accessible and diverse palliative care system across South Australia.

Hon Chris Picton
Minister for Health and Wellbeing

About the Palliative Care 2022 Grants Program

The Palliative Care 2022 Grants Program is an initiative of the South Australian Government and conducted in partnership with Palliative Care South Australia (PCSA) to work with and support innovative non-government organisations who bring new ideas to improve and diversify palliative care.

The Program focuses on the four areas of unmet need identified in the National Palliative Care Strategy 2018 and the SA Palliative Care Strategic Framework 2022-27:

- Improve palliative care data collection, monitoring and reporting.
- Extend palliative care support to patients and practitioners treating non-malignant diseases.
- Improve access to palliative care in the community (including grief and bereavement).
- Increase the number and involvement of primary care practitioners in palliative care.

For the 2022 round, a total of $876,000 was made available to non-governmental organisations working with or interested in trialing projects in palliative care.

Awarded projects

A total of 13 projects from the following organisations were awarded a grant through the Program:

- VIVA Mutual Foundation - VIVA Pal: Navigating Palliative Care Options for the Disability Community
- South Australian Postgraduate Medical Education Association (SAPMEA) - Supportive and Palliative Care for Dementia
- RDNS Silverchain - Early Identification of Clients at Risk of Deterioration or Dying with Non-malignant Disease
- The Pharmaceutical Society of Australia - Palliative Care Pharmacist Home Service in Regional SA
- The Pharmaceutical Society of Australia - Palliative Care Pharmacist Aboriginal Health Services
- Occupational Therapy Australia - Palliative Care Webinar Series
- The Motor Neurone Disease Association of South Australia (MNDSA) - Talking Grief (Loss, Grief and Bereavement Volunteer Program)
- In Home Hospice Care - In Home Hospice Care Mount Gambier
- Helping Hand Aged Care - Palliative Care Holistic Leaders Program
- Healthy Cities Onkaparinga - HCO Compassionate Communities
- GP Partners Australia - Project ECHO (Extension for Community Healthcare Outcomes) – Enhancing Palliative Care
- Flinders University - Experience of Unpaid Family Carers on Access to Palliative Care and Self-care Information, Resources and Services
- Flinders University - Enhancing Dignity with Personal Care at the End-of-Life in Residential Aged Care

VIVA Mutual

VIVA Pal: Navigating Palliative Care Options for the Disability Community

About the project

The VIVA Pal Project focused on supporting people living with disability to navigate palliative care options in the community. Key objectives of this project also included the identification of clients with an Advance Care Directive (ACD) and the creation of processes during client onboarding to activate a conversation about ACDs.

As a not-for-profit organisation and NDIS registered service provider, VIVA Mutual delivers at home support and community nursing services for people living with disability. The organisation provides an innovative model comprised of self-managed teams focused on employee engagement and empowerment.

For this project, VIVA Mutual partnered with Mitch Fox from Simple Healthcare Solutions who has worked with the organisation before on hospital avoidance, and primary and community care outcome improvement. For VIVA Pal, Simple Healthcare Solutions conducted data evaluation and analytics, as well as stakeholder engagement, reporting, surveys, workshop planning and design.

Through the VIVA Pal Project, the organisation took a closer look at VIVA Mutual systems, processes and communication around palliative care options for clients. Engaging with clients and their family/guardian, as well as healthcare professionals has been key to developing better processes that are tailored for the disability sector.

The project involved an internal audit, engagement with consumers, a co-design phase, and recommendations and reporting. The internal audit enabled the identification of clients that had an ACD, information held on file relating to their ACD status, and the accessibility of this information to support service providers. It also involved connecting with client general practitioners (GPs) to validate that client details were up to date.

This was followed by engagement with over 100 clients to explore their knowledge of the palliative care options available to them, as well as the benefits of having an ACD. Meetings were conducted by VIVA nursing staff and included a client's GP who may be involved with or linked into the ACD.

The recommendations that have been developed from the project are tailored to client engagement. They support improved documentation and recommendations will assist support providers to navigate the care system in their clients' best interests and support them to make choices at end-of-life.

The project has been presented at VIVA Mutual events where support coordinators, plan managers, other support providers, local council and Local Area Coordinators were provided with updates on the program.

What’s next?

Next steps will involve ensuring all new and existing clients are taken through a questionnaire to identify if they have an ACD, and to provide them with information about ACDs and their benefits.

Knowledge sharing meetings on the palliative care options available to clients, as well as the benefits of having an ACD are currently being coordinated by the VIVA nursing staff. Client GPs will be encouraged to link into communication and existing ACDs.

A ‘VIVA Different Conversation Series’ was initiated in early 2023. The next topic for discussion will focus on ACDs and be held in the Adelaide Hills with the Country PHN and local Councils.

Quotes

> *“Where clients had no Advance Care Directive, they were happy for and welcomed assistance in navigating the process of starting an ACD plan, and having one of our nurse team members connect them with their GP and other stakeholders”*
>
> **VIVA nurse interviewer**

> *“Delivering palliative care to clients in the community is smoother if a client has an ACD because there is clarity about their wishes and it’s recorded. We run into challenges when there a different opinions from family and guardians and a client’s wishes aren’t documented. Having a plan makes it easier for all stakeholders”*
>
> **Palliative Care Nurse Lead**

Telling the story

“Being a Community Nurse Lead at VIVA Mutual, I have been performing quality improvement surveys with clients as part of my role. One of the questions we now ask our clients states; “Have I discussed and shared my Advanced Care Directive with my GP?”.

While going through these questions with our clients, a number of them ask me “What does this Advance Care Directive mean?”. I have realised that most of our clients don’t have any knowledge about ACDs.

Some clients are reluctant to have ACDs for personal reasons. Others, despite knowing the importance of ACDs, have refused to speak to their doctors because they don’t believe in its relevance, and that they feel they are going to live longer. This is due to the lack of knowledge of what an Advanced Care Directive is.

Clients don’t understand that ACDs are relevant for any age group and are not age specific. It takes persistence and time to work through their concerns and for them to see the value in having an ACD. Therefore, the importance of a health care professional to assist them to understand this is vital.

Having asked this question, we feel we are being more supportive with their care and our clients are feeling the same.”

Community Nurse Lead

Visit: vivamutual.org

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South Australian Postgraduate Medical Education Association (SAPMEA)

Palliative Care in Dementia Project

About the project

The Palliative Care in Dementia Project aimed to increase the capability and capacity of primary healthcare professionals in providing supportive and palliative care for people with dementia and their families/carers through the provision of education and learning support.

Partnering with South Australian Postgraduate Medical Education Association (SAPMEA) in this project were Palliative Care SA, Dementia Training Australia, and Dementia Australia.

The project had two components, including:

- a full-day face-to-face symposium, and
- a seven-part online learning and mentorship program called Project Extension for Community Healthcare Outcomes (ECHO).

Feedback from participants of the symposium and ECHO sessions were positive and indicated that the project met its objectives.

Dying Well with Dementia Symposium

A full-day symposium titled “Dying Well with Dementia” was held on 11 February 2023, with attendance from 104 healthcare professionals across a broad range of clinical disciplines, including nurses, doctors, pharmacists, physiotherapists, and extended care paramedics.

The symposium featured a range of real-life patient videos and presentations from a panel of local experts. Several palliative care and dementia service organisations were invited to have a stand at the symposium to promote and share information on their services, including Palliative Care SA, The Hospital Research Foundation Palliative Care, HealthPathways SA, Dementia Support Australia, Dementia Training Australia and Dementia Doulas International.

The symposium evaluation achieved the following ratings from participants:

- 100% of participants reported that they had gained awareness and knowledge related to best practice palliative care in dementia.
- 97% of participants reported that they had gained awareness and knowledge related to support services and referral pathways in dementia.

Advanced Dementia ECHO Program

The seven-part program was launched on 28 February 2023, with sessions held fortnightly. The Advanced Dementia ECHO Program received 119 enrolments from a broad range of clinical disciplines and participants were invited to present a patient case at each session.

ECHO participant responses to Session 1 & 2:

- 97% of participants reported that they had gained relevant and valuable learnings that they could apply to their practice.
- 100% of participants reported that they are confident to provide management and quality care to their patients following participation in the ECHO session.
- 97% of participants reported overall satisfaction with the learning opportunity provided by the ECHO sessions.

What's next?

SAPMEA is exploring opportunities to deliver further ECHO programs focused on dementia and palliative care.

Quotes

> *"It was excellent, loved all the speakers. Good wide range of speakers / subjects. The venue was lovely, food great, presenters wonderful. Well done to the organisers!"*
>
> **Symposium participant**

Telling the story

For the Advanced Dementia ECHO program, a different GP presented a case for discussion at each session. The case presenter for the first session was Dr Suni MacDonald and the case presenter for the second session was Dr Adelaide Boylan. Both cases generated great discussion amongst the panel and participants.

Dr MacDonald and Dr Boylan have fed back that they highly valued the opportunity to present their case to the ECHO network and expert panel. Both doctors shared that the group discussion and feedback they received on their case will help them to enhance the quality of care that they can provide to the patient.

97% of participants who attended the ECHO sessions where Dr MacDonald's and Dr Boylan's cases were presented shared that the case discussions met their learning needs and they gained relevant and valuable learnings to apply to their practice.

The recording from panel presentations and resources from all Advanced Dementia ECHO sessions can be accessed at: sapmea.asn.au/echo/dementia

Visit: sapmea.asn.au

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RDNS Silverchain

Early Identification of Clients At Risk of Deterioration or Dying with Non-malignant Disease

About the project

The aim of this project was to build the confidence and knowledge of RDNS staff in a range of roles through bespoke education packages that support the early identification of clients with non-malignant diagnoses at risk of deterioration or dying and applying a palliative approach to care for clients nearing end-of-life.

Objectives included the education and upskilling of direct care RDNS staff to ensure they had the knowledge and confidence to recognise:

- when a client was deteriorating or dying
- when clients should have a generalist palliative care approach, and
- when to make a timely referral to receive a specialist palliative care service.

Care workers attended a 90-minute education workshop delivered by a palliative care nurse educator. The Supportive and Palliative Care Tool (SPICT) 4ALL Tool was introduced and the importance of Advance Care Directives discussed with home care package coordinators. To support and embed this practice, staff were educated and information recorded in the RDNS client management system.

To date, 100 staff have attended a one-day workshop provided by Hammond training, including caseworkers, case coordinators, clinical nurses, and senior registered nurses. RDNS has plans to continue to upskill staff throughout 2023.

Nurses working in the field attended a three-hour workshop and a series of online modules, followed by a buddy shift to embed learnings and complete syringe driver competencies.

Embedding a palliative approach has enabled a focus across a broader scope of direct care providers, reaching larger numbers of clients whose referrals would not ordinarily sit within the End of Life South Australian Community Care Program provided by RDNS.

The greatest impact observed is improved awareness, confidence and knowledge in staff providing care to clients. Staff not otherwise associated with palliative care have shown an increased knowledge and skill in embedding a palliative approach as per the staff evaluations that have been completed.

There has also been a 10.3% increase in home care package clients with Advance Care Directives as a result of embedding of the palliative approach.

Staff confidence to place referrals and escalate to both medical and nursing teams appropriately has also increased as per staff evaluations pre and post education.

Internal reports indicate a higher number of clients receiving a palliative approach towards care, with or without dedicated palliative care funding. Categories have been developed in the client management system which provide identifiable evidence of approaches to embedding a palliative care approach. Gaps in approach are now identifiable and easily rectified.

What’s next?

There are future plans to embed palliative care education workshops as business as usual amongst new and existing RDNS care workers. This will also include:

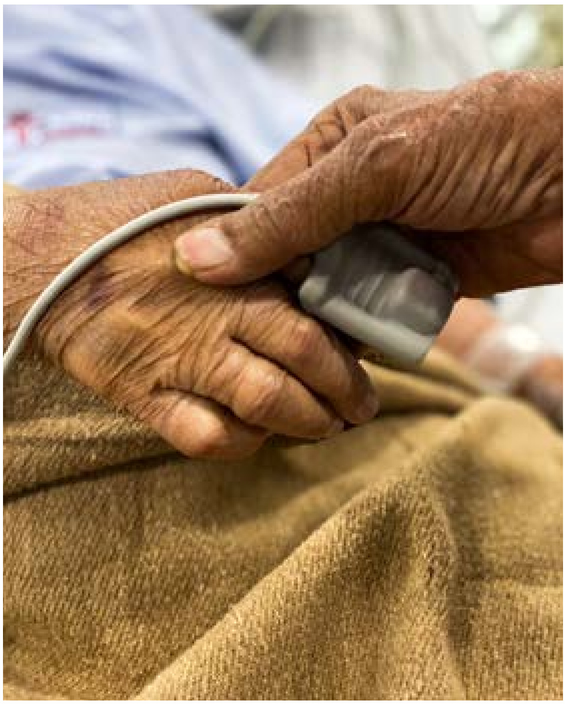
> Continuing care worker education at induction and onboarding to RDNS.

> Continuing monthly team meetings with home care package coordinators to support and identify clients requiring a palliative approach within home care packages.

> Continuing and expanding registered nurse upskilling education workshops.

> Continuing to support and coordinate buddy shifts from the RDNS palliative care teams and general nursing managers to build capability.

> Collaborating with internal and external palliative teams and generalist nursing teams to promote best preventative palliative care to clients.



Telling the story

*Mark** is a 75-year-old man with chronic lung disease living at home without family support. With a Level 3 Home Care Package (HCP), he currently receives domestic and personal assistance throughout the week.

Mark has been experiencing slightly increased shortness of breath over the last two weeks. Care workers have noticed a decline in his mobility and endurance at time of showering and have reported the changes to his HCP coordinator.

The coordinator phones Mark to follow up on the observations made by the care workers. As a result, Mark agrees to nursing input to assess increasing symptoms and needs. His clinical observations indicate a decline in lung function and activities of daily living.

The option of a palliative approach to care is discussed with Mark by his coordinator and nurses. Advance care planning is arranged with support from social workers and clinical assessment by nursing is factored into his HCP funding. The SPICT 4 ALL Tool supports non-clinical changes to care and promotes early identification and escalation when Mark starts to decline.

Mark’s care workers, coordinator and nurses therefore work effectively and collaboratively to manage his escalating needs and embed a palliative approach to his care at an earlier point in time. Additionally, Mark’s wishes are recorded and documented in an Advance Care Directive, enabling him to clearly communicate his care preferences he approaches the end of his life.

**Not their real name*

Visit: www.silverchain.org.au

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Pharmaceutical Society of Australia

Palliative Care Pharmacist Home Service in Regional SA

About the project

The Pharmaceutical Society of Australia (PSA) has developed a pharmacist practice model to support healthcare professionals and their palliative care patients by embedding a pharmacist within community and home care settings in regional South Australia.

Focusing on collaboration with the multidisciplinary palliative care team, the community palliative care pharmacist service model was developed to work with general practices, regional healthcare professionals, supported living and aged care facilities, as well as patients and their families to improve understanding, knowledge, trust, and confidence in medications and symptom management.

Distance, travel, costs, and health literacy can be significant barriers to palliative care patients and their carers accessing medications and pharmacy services in regional areas. The project was developed to address these barriers through the addition of a pharmacist resource to enhance existing palliative care provision in the state's Mid-North region.

A digital interaction log was reviewed and identified an opportunity for a community-based pharmacist to collaborate with multidisciplinary teams and palliative care patients to enable:

> Easier navigation of the health care system.

> Access to medicines and clarification on medication related issues.

> Support to help patients stay home for longer, especially for those unable to travel easily.

> Assistance in implementing a doctor's message or plan.

> Building patient and family confidence.

Through this model, the pharmacist:

> Advises, educates, and supports healthcare workers, patients and their families with medication and symptom management.

> Complements traditional 'clinical' or 'community' pharmacists by providing comfort and increasing support to enable people in regional areas to remain where they are, for as long as possible.

> Aims to free up GP and nurse time for patient follow-up and support by liaising between health professionals and improving communication, especially after-hours.

> Supports better access to targeted information and education in medications used in palliative care alongside chronic disease management.

To enable successful implementation, the pharmacist initially focussed on building trust and relationships between PSA and the local healthcare teams in the region. The project has since demonstrated a positive impact on collaboration between existing and emerging palliative care services in the community. For example, activity including consults with patients, education, and liaison with nurses, doctors, and local pharmacies is increasing.

The establishment of a palliative care focussed pharmacist has also demonstrated benefits for patients and their families. An experience survey was conducted and demonstrated that the knowledge and confidence of patients and their carers improved with the introduction of the community palliative care pharmacist service model.

What's next?

The project has demonstrated that a pharmacist practice model focussed on multidisciplinary collaboration improves support for palliative care patients and enables access to right care at the right time.

PSA would like to continue to support palliative care in the home and community setting in regional SA through:

- Co-design and expansion of this new role for pharmacists in palliative care to more regions across South Australia.
- Building resources to support healthcare professionals.
- Developing mechanisms to identify patients earlier for support and referral to Pharmacists and commence home consultations.
- Advocacy for every community palliative care team to be resourced with a dedicated pharmacist for their community service.

Learnings from this project have contributed towards PSA's successful application for a grant under the Australian Government's National Palliative Care Grants Program. The funding will be invested in palliative care education for pharmacists and the pilot of a new community palliative care pharmacist service model.

Quotes

> *"To have a pharmacist and their skills integrated to the existing healthcare team has enabled a support that until now has not existed. One nurse commented "Tash [Home Service Pharmacist] is awesome. We cannot do without her now"*
>
> **Helen Stone, Pharmaceutical Society of Australia State & Territory Manager SA/NT**

> *"The pharmacist can be the link between doctors, nurses, palliative care nurses and staff"*
>
> **Project Pharmacist**

Telling the story

*John** is an 89-year-old male with chronic renal failure, recent history of pneumonia, ureteric calculus, gastroesophageal reflux disease, congestive cardiac failure, macular degeneration (limited vision), osteoarthritis, ischaemic heart disease, limited mobility and is on home oxygen.

Tash is a pharmacist in a regional general practice, working with regional palliative care teams. Following his recent discharge from hospital, John was referred to Tash. Reasons for the referral included the significant decline in his health and concerns about his medication compliance. To optimise John's care, Tash liaised with the multi-disciplinary team which consisted of GPs, allied health professionals and community health workers, as well as carers and family members.

Tash was able to:

- improve John's medication understanding and compliance
- review medication dosages in line with John's current renal function
- identify potential drug interactions
- reduce tablet burden
- discuss potential adverse drug reactions
- discuss appropriate storage and disposal of medications
- undertake medication reconciliation (the medication lists differed between health professionals involved in John's care)
- improve John's inhaler technique

Tash's intervention enabled better outcomes for John and his wife. John reported being more comfortable, and he was able to stay at home for longer due to Tash's support. Tash will continue to follow up with John as his needs change and he progresses through each stage of the palliation process. Ongoing support will be provided to John's family members during their bereavement.

**Not their real name*

Visit: www.psa.org.au

Contact: Leah Robinson, Project Manager, Pharmaceutical Society of Australia - Leah.Robinson@psa.org.au

Pharmaceutical Society of Australia

Palliative Care Pharmacist Aboriginal Health Services

About the project

The Pharmaceutical Society of Australia (PSA) has developed a practice model that involves embedding a palliative care pharmacist within an Aboriginal Community Controlled Health Organisation (ACCHO) to improve understanding, knowledge, and confidence in medications for Aboriginal patients and families, and the healthcare professionals that support their care.

Through this project, three pharmacists have been introduced to work with multidisciplinary palliative care teams in ACCHOs across two regions: Port Lincoln Aboriginal Health Service (PLAHS) and Whyalla at Nunyarra Aboriginal Health Service (NAHS).

Acknowledging the need for palliative care models that are appropriate and aligned with Aboriginal peoples' community values, beliefs, cultural/spiritual rituals, heritage, and place, the pharmacist model provides clinical support, consultation, and education on all levels, with a focus on appropriate medication use, best patient experience and comfort.

The initial focus of the project was to:

- introduce the pharmacist role,
- develop collaborative partnerships with service providers, and
- identify implementation challenges.

Consequently, pharmacists established collaborative partnerships between key personnel, including discharge planners, community pharmacists, hospital pharmacists & the palliative care team. It has since been observed that the role of the pharmacist has not only been accepted but welcomed, enabling them to support transitions of care and management of medications and side effects.

Some challenges to successful implementation of the model have also been identified, including:

- How to approach the concept of palliative care in each Aboriginal community.
- Developing methods to identify patients.
- Optimising collaboration with other healthcare workers.
- Finding appropriate resources for education.

Pharmacists have been working on building trust with the community to optimise appropriate access to patients who may benefit from a palliative approach. This approach is critical for Aboriginal communities, based on feedback from ACCHO staff, as trust in the pharmacists and their role helps patients to engage in care.

They are also working with health services to recognise patients not routinely identified as receiving palliative care. This includes other patient groups that would benefit from earlier support, not just those presenting to services for end-of-life care.

Early patient identification is being achieved by establishing a mechanism to recognise patients with diagnoses of potentially life limiting chronic diseases through clinical software. A digital interaction log and survey has been set up to record and evaluate the pharmacists' interactions with patients, families, carers, healthcare professionals and services. After the initial role establishment, interactions are now focussed on quality use of medicines in a trusted relationship.

Some of the impact of pharmacists on palliative care provision is best illustrated by feedback from patients and their families. One of the pharmacists was recently given permission to call a patient "Aunty" after supporting her through sudden onset medical emergencies, resulting in changes to her medications.

What's next?

PSA would like to further support palliative care in the ACCHO sector by:

- Exploring and co-designing new roles for pharmacists in palliative care.
- Building resources to support ACCHOs.
- Developing and supporting mechanisms to identify patients earlier for support.
- Assisting with clinical governance for medication related issues.
- Advocating for funding for every ACCHO to have access to a pharmacist.

A potential model of care for a pharmacist in Aboriginal palliative care services could also be developed, with this pharmacist role used as a case study. This would include co-design with local Aboriginal people and the palliative care team.

Quotes

> *"Initially in the project, a common response when mentioning Palliative Care was; "We don't do Palliative Care" and the stigma, fear and culturally appropriateness to raise this. This project and the approach of the pharmacist within the ACCHO helped people to destigmatise palliative care"*
>
> **Project pharmacist**

> *"The pharmacist has a significant role in the quality and safe use of medications for all people, including Aboriginal and Torres Strait Islander people in their palliative care journey."*
>
> **Project pharmacist**

Telling the story

*Sue** is 89 year old Aboriginal woman who lives at home with her husband, who is her carer. She has a medical history of type 2 diabetes, chronic kidney disease, hypertension, and asthma.

Kylie is a pharmacist working within the Aboriginal Community Controlled Health Service (ACCHO). She knows Sue's family as she previously arranged a Dose Administration Aid (DAA) for Sue's son, who has an intellectual disability. Sue's initial contact with Kylie was 12 months ago.

Recently, Sue's condition has begun to deteriorate, and a Home Medicine Review (HMR) has been requested by her new GP. This was followed by a referral to palliative care for Sue, and consent was obtained to allow a pharmacist to come and talk to her about her medications. Kylie walked Sue through some of her recent medication changes such as deprescribing oral diabetes medications and vitamin D. Kylie also provided advice regarding insulin use and changing targets for blood glucose control.

Kylie will continue to follow up with the whole family in future and be an accessible point of contact. Care will be delivered in collaboration with Sue's GP and palliative care services, with Kylie an integral member of the team.

**Not their real name*

Visit: www.psa.org.au

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Occupational Therapy Australia

Palliative Care Webinar Series

About the project

Occupational Therapy Australia (OTA) has developed a high-quality, evidenced-based learning resource to increase the knowledge, skills, and capabilities of occupational therapists working as primary healthcare practitioners in palliative care.

The webinar series and learning resource has been designed for OTs access and learn at their own pace. The resources aim to increase capacity, confidence, and ultimately improve recruitment and retention outcomes for OTs working in palliative care.

The three-part web series addresses an identified training gap for OT and includes:

1. Introduction (basic knowledge)
2. Developing skills
3. Ethical considerations (aimed at addressing some of the more complex situations occupational therapists may face in practice)

The learning objectives focus on building capabilities for occupational therapists through:

- Skills in optimising quality of life and promoting occupational performance over the course of disease progression.
- Symptom management such as fatigue, breathlessness and pain through assessment, energy conservation techniques, education, counselling, task redesign and equipment prescription.
- Enabling individuals to remain in/return to the place of care of their choice.
- Adaptation and coping skills with the challenges associated with life limiting illness.
- Supporting capacity to attend to affairs and the development of legacy.
- Specialised assessments with targeted interventions, such as education and environmental modifications, to support an individual’s ability to manage safely within their own home.
- Caregiver support, education, and training to reduce risk of injury, negative experiences, and grief and bereavement support (including complex bereavement).
- Supporting smooth transition and continuity of care across community and acute services.

A project manager has been appointed to drive project coordination, and two authors have developed and produced content for the learning and development resource. Content for all three modules has been written and is being built into an online platform.

The project has so far also enabled the development and fostering of relationships between Occupational Therapy Australia and South Australian occupational therapists, as well as collaboration between professional associations, academics, and clinicians in palliative care.

What's next?

OTA will build on the foundational skills learning and development modules to offer learning and development for mid and advanced career occupational therapists working in the palliative care sector.

Through the project, the ongoing collaboration with Flinders University will allow for an assessment of the impact of training for participants.

It is also anticipated that the project will raise awareness of the capabilities and clinical capacity of occupational therapists in the palliative care sector.

Quotes

> *"An invaluable learning and development resource for occupational therapists practicing in the palliative care sector"*
>
> **Palliative care occupational therapist and webinar presenter**

Visit: otaus.com.au

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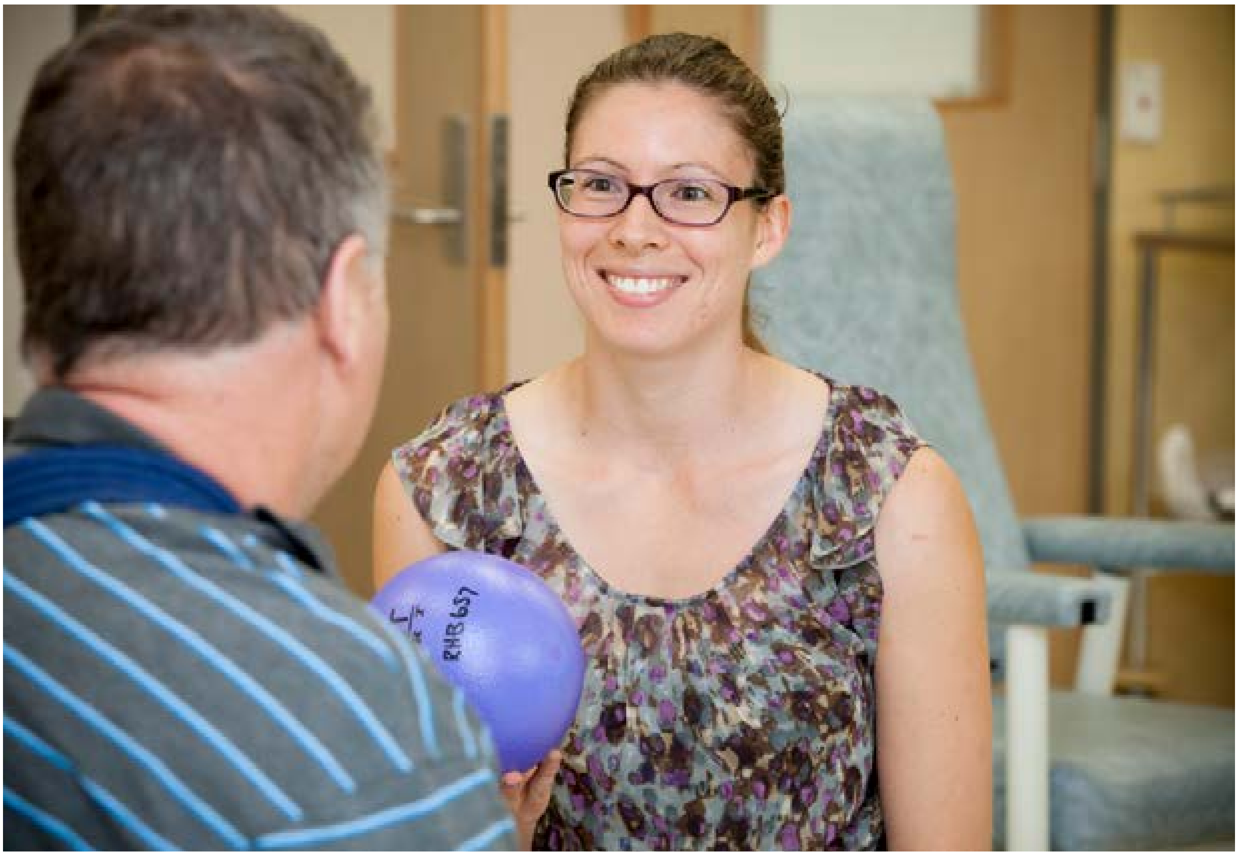


Motor Neurone Disease Association of South Australia (MNDSA)

Talking Grief (Loss, Grief and Bereavement Volunteer Program)

About the project

Few illnesses are as confronting and disruptive as motor neurone disease (MND). A diagnosis of MND begins a journey of inevitable decline through progressive immobilisation into death.

Approximately 150 MNDSA clients, their carers and family including children are impacted by a diagnosis of MND at any one time in South Australia. There is considerable evidence that palliative care interventions improve quality of life for people living with MND and their carers.

MNDSA developed the Talking Grief program, a sustainable, state-wide loss, grief, and bereavement support program to help South Australians impacted by a diagnosis of MND. This program aims to help families better understand and manage the negative impacts that can be caused by the exceptional level of strain the MND caring role entails.

Volunteers are recruited and trained to build skills and knowledge to provide loss, grief, and bereavement support, know when to refer to professional grief counsellors, and how to care for themselves whilst supporting others.

Volunteers provide regular support opportunities to engage clients and their carers; and help mitigate feelings of grief, including isolation, depression, anxiety, and fear.

MNDSA aims to establish a network of trained volunteers to provide weekly support opportunities to clients, their families and support networks.

The program currently has six volunteers, with 12 new volunteers going through the application and induction process. A new training program has been developed to ensure thorough and detailed education around MND is provided to support our volunteers to succeed in their client relationships.

The Volunteer Coordinator has also worked on a referral process with the MNDSA Client Services team; and this relationship will continue to be built on as the program expands.

What’s next?

As the Talking Grief Program grows, MNDSA are looking at how it will be promoted within the immediate and wider community. The Volunteer Coordinator has begun the process of engaging with community groups run within the MND environment, with the aim of increasing awareness of the project and existence, and also to begin to look at it as a source of support, information, and comfort.

There will be a focus moving forward on strengthening the relationships with the MNDSA Client Services team to facilitate referrals and also providing knowledge to clients as they are linked in with MNDSA. Previously, clients and their families and friends were limited in who they could connect with for support. Now, the Talking Grief Program not only provides this support but is becoming a source of information, as well as comfort.

Key learnings have been shared with other state MND associations, and resources will be made available to other agencies once fully tested. This will help expand the loss, grief, and bereavement support available throughout the community both in South Australia and nationally.

The final stage of the funding period will see the program grow to a total of 12 volunteers actively supporting clients.

The Volunteer Coordinator will be working with the MNDSA Client Services teams to engage clients in the Talking Grief program and expand to provide also support groups, for people who feel more comfortable in a group setting rather than on their own.

In the future, the program will be looking at recruiting and training volunteers in country areas to support our clients living in those communities. There are plans in place to further expand the sharing of key learnings and resources to grow the availability of this type of support in South Australia and beyond.

Quotes

"It is lovely to have someone who is there to focus on me, the person, to talk about what I want to talk about"

MNDSA Client

"I enjoy that my volunteer work in the Talking Grief Program allows me to combine what I am passionate about with a worthy organisation. When I connect with my client I know that I am providing him with an outlet to talk about whatever is on his mind, It's a great feeling to know that what I am doing is making a difference in someone's life"

MNDSA Volunteer

"Everyone's journey is different, and our volunteers are trained to be there to help with the difficult questions and thoughts. Just giving people permission to express their concerns provides a measure of relief"

MNDSA Support Coordinator

Telling the story

*Helen** was diagnosed with MND in February 2022 and saw many changes to her life as a result. She moved interstate to Adelaide into a residential aged care facility to be closer to her daughter who is her main support. While she enjoys visits from various family members, Helen often finds that visitors talk about what they are up to, as opposed to how she is managing with her illness. Helen states that she finds this a little frustrating.

Since matching with her Talking Grief Volunteer, Helen has someone to talk to and is finding it very beneficial. She acknowledges that family don't always want to talk about the progression of her illness, so having the volunteer to talk to allows her to discuss fears and concerns in a safe environment, where she will be supported and encouraged.

Helen says that she understands that her volunteer "doesn't know everything", but they are providing her with a level of comfort and ways to ask for more information, knowing that they will help her to access what she needs.

**Not their real name*

Visit:
www.mndsa.org.au/social-and-emotional-wellbeing

Contact: Kerry McMullan, Director Care Services, Motor Neurone Disease Association of South Australia (MNDSA) – kmcmullan@mndsa.org.au

In Home Hospice Care

In Home Hospice Care (IHHCare) Mt Gambier

About the program

Established in 2020, In Home Hospice Care (IHHCare) is a not-for-profit, community organisation based in Mount Gambier. IHHCare supports people with a life-limiting illness and their caregivers by providing non-medical, practical, and emotional support in the home. Services are free and include (but are not limited to) in-home caregiver respite, companionship, social engagement, and transportation.

IHHCare operates in a collaborative model with local health service providers (for example, the Specialist Palliative Care team located at Mount Gambier Hospital), adding value to existing health and care services operating within the community. Its organisational goal is to provide people with a life-limiting illness the best opportunity to be cared for at home until the very end of their lives, regardless of their age, diagnosis, social context, or financial resources.

Consistent with a compassionate community public health approach to end of life care, IHHCare operates a volunteer-based model of care. Through this program, local community volunteers are matched to clients based on their social and cultural backgrounds (so that there is common ground when meeting with each other the first time) and individual needs.

The desire to be independent has long been identified as being of high importance to clients with life-limiting illness, and volunteers support clients to retain some degree of self-sufficiency and opportunity to live with dignity for as long as possible.

Volunteers support emotional needs, such as providing someone to chat with, and physical needs, such as helping people get out into the community.

Volunteers undertake the Palliative Care Victoria Volunteer Training Program prior to commencement. Ongoing support is provided by staff who offer continuing education and supervision of the volunteers, along with management of client referrals and day-to-day operations.

IHHCare has also recently employed a Grief and Loss Counsellor (funded by Masonic Charities), who provides emotional and psychological support to clients and their caregivers, as well as to staff and volunteers.

What's next?

IHHCare is developing a three-year strategic plan, which builds on the achievements of the establishment phase and focuses on sustainability. The organisation will undertake engagement with a broad range of stakeholders, recognising that development of these networks into supportive partnerships will increase opportunities that enable service growth, sustainability, and further expansion.

Building on the development of this community, the next steps for IHHCare are to integrate volunteer support into local hospital and aged care facilities and expand the reach of program services to Penola and Millicent.

Quotes

"I have had tremendous support from In Home Hospice Care – they made the process of my wife's end of life journey so much easier for me. The people there have so much empathy and they listen; and I could vent without being worried about being judged. It ends up they become part of your family"

IHHCare client

"I just want to say thank you for helping me in this difficult time. Losing my mum brought a lot of difficult emotions and feelings with my loss.

You have helped me unscramble my mind and understand how to move forwards as a stronger person. You have listened to my ramblings and have helped me see what was at the core of my problems. Thank you. If not for you I would still be lost"

Counselling service client

Telling the story

The following story comes from a carer who utilised Mount Gambier IHHCare program when her partner was receiving palliative care:

"My partner was sick with cancer and then had a stroke not long after the cancer diagnosis, which stopped the treatment. We had to look into palliative care and after some research I found Mount Gambier In Home Hospice Care."

"The key thing really is the matching of the carers and clients to the volunteers and making sure we have something in common. We got on really well with the two volunteers allocated to us and having them visit once a week meant I could go out shopping or do anything I had to do, without worrying about my partner."

"Having them was quite motivating for my partner as well, because there were a few times where I would tell him they were coming and he would get up and out of bed and by that time, he was much weaker and wasn't getting up very much."

The following reflection comes from a volunteer and describes their experience of participating in the program:

"By having this service available, it is enabling carers to continue their very heavy work by giving them a bit or relief, or a bit of change. As the program is a community-structured response, one of the benefits to me is that I am helping my fellow community members. I have also come to appreciate that people can grieve, but still have positive experiences at the same time."

Visit: www.inhomehospicecare.org.au/

Contact: Sandi Elliott, Hospice Manager, manager@ihhcare.org.au

Helping Hand Aged Care

Palliative Care Holistic Leaders Program

About the project

The Palliative Care Holistic Leaders Program engages senior registered nurses within Helping Hand's residential and home care services to create a leadership team and community of practice to improve palliative and end of life care delivery across the organisation.

As a part of the program, 13 registered nurses have now completed the Professional Certificate in Palliative Care with project partner, University of South Australia.

Throughout the thirteen week study period, the leadership group also met for four dedicated training days to share learnings, build relationships, and hear from experts in palliative care.

Within this program, Helping Hand has developed a Palliative Care Strategic Plan and updated its Advance Care Directive documentation.

It is also the first aged care organisation in South Australia to adopt the PACOP (Palliative Aged Care Outcomes Program) process, a nationally recognised program designed to optimise palliative care outcomes for residents living in residential aged care.

The Helping Hand Social Work team also supported the project by conducting interviews with family members, as part of an evaluation process.

What's next?

Through the grant, Helping Hand has enhanced existing levels of nursing care by creating an environment of compassion and empathy.

The leadership group will work together to design the best process for sharing their learnings with other staff at Helping Hand.

The group is also informing the design of an internal staff training tool which will be translated in to at least three languages other than English.

The leadership group, family members, and staff who have had learnings shared with them will participate in post-project evaluation which will provide insight into impact and outcomes.

Quotes

"After completing the palliative care course, I have learnt the skills of applying compassionate communication with the resident, their family, and friends. Understanding the key components has made me feel calm and comfortable when having to discuss end of life wishes and palliative care."

Palliative Care Holistic Leaders Program participant

"It was a scary feeling prior to doing the course, but afterwards it made me realise that it is a natural process and it can be easy and smooth if the wishes can be met, therefore it made a huge difference"

Program participant

"The main difference is that I will talk human to human and not nurse to client. I feel that way because we deal with people who want to be treated with care and empathy during grief"

Program participant

Telling the story

"As a palliative care nurse, I understand the anxieties and fears surrounding the palliative care journey and that every family's journey is unique.

Through the grant, our processes and approaches are now more coordinated and inclusive. This has enhanced existing levels of care with more compassion and empathy. The creation of Palliative Care Holistic Leadership group has resulted in a team approach of care and support.

Whether it is coming together with the family to develop an advance care plan or practicing compassionate communication, we create a pathway of relief, and a vision for care that reflect the wishes of the resident and their family".

Program Participant

Visit: www.helpinghand.org.au/

Contact: Kerry Catt, Advance Practice Consultant, Helping Hand Aged Care - kcatt@helpinghand.org.au

Healthy Cities Onkaparinga Inc.

Establishing a Compassionate Community

About the project

Drawing on the experiences of Healthy Cities Onkaparinga (HCO) and Southern Vales Compassionate Communities (SVCC), the Onkaparinga Compassion Communities Collaborative (OCCC) aims to develop an independent, incorporated, umbrella organisation and local Compassionate Community groups.

Compassionate Communities are a recognised public health approach to palliative care. They provide support to communities, health practitioners and palliative care services by increasing the volume of community volunteers working in palliative care. By filling gaps with community support, people approaching end of life and their carers are better assisted to focus on what matters most to them.

HCO is an NGO established in 1987 under the World Health Organisation's Health Cities Project, working to enhance health promotion, equity, and cross-sector collaboration to improve the health of the community. SVCC is a community-based group active in the McLaren Vale / Willunga region and has two years' experience in hosting death cafés, art therapy courses and other grief support activities.

The OCCC supports local Compassionate Communities groups by providing governance, strategic planning, community development expertise, coordination, mentorship, promotion opportunities, and assists with grant applications and volunteer recruitment. A variety of local initiatives will be trialled by the emerging Compassionate Communities groups.

Two community forums have been held to date. The first in November 2022 with over 45 attendees introduced the concept of Compassionate Communities and launched the project.

In December 2022, over 50 people attended a workshop to set priorities and identify and plan group activities to be conducted throughout Onkaparinga.

Four new groups have been identified: two are geographically based groups at Aldinga/Aldinga Beach and Hackham West, and two are issues-based groups – Care4Blokes and Compassionate Conversations.

With SVCC, the Compassionate Communities groups have started putting their planning into action with death cafés, art groups, training opportunities and resource production is underway.

What's next?

The two community forums increased awareness of Compassionate Communities and provided opportunities for knowledge sharing, partnership development and recruitment of a large number of volunteers. With continued growth in SVCC, and four new local groups now starting their activities, there has been an increase in programs and support for people approaching end of life and their carers.

Attendance at death cafés demonstrates the persistent unmet need for people to come together in a safe and welcoming environment to discuss issues of death and dying, grief and loss.

The OCCC is actively working on incorporation and developing a constitution and policies to support the new organisation. A name change will reflect interest received from areas outside of Onkaparinga to cover a larger southern region.

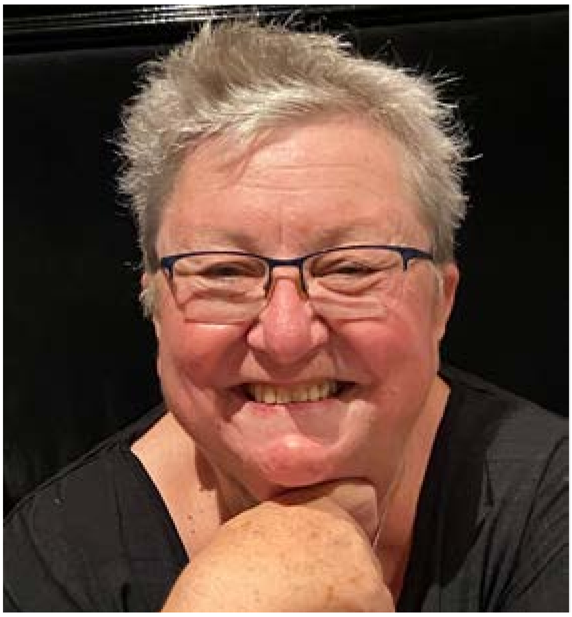
A funding application is being written to support further consolidation of the new organisation, training and support for volunteers and a systematic evaluation. Also included in the application is support for a community-based conference in 2024 to showcase achievements, increase awareness and participation, and consider the evaluation findings.

Meanwhile local groups will continue to roll out their action plans and engage with community and other stakeholders.

Quotes

> *"I thoroughly enjoyed the Art for the Heart program. It allowed me the freedom to create in a safe space. The facilitators were respectful, fun, caring, and provided a wonderful environment to learn and grow. Thank you."*
>
> **Art for the Heart participant**

> *"Community connectors are the key to being able to help people to take control of their wellbeing and health. They are instrumental in being able to assist and guide people as they navigate their way through the health system"*
>
> **Steering Group member**



Telling the story

Angela was on the doorstep of the End-of-Life Wellness and Care Expo an hour early. She was on her gopher with her oxygen bottle before any of presenters had set up. She stayed for three hours, speaking to every stallholder including the death doulas, funeral directors, and Advance Care Directive experts. The 'Threshold Singers' sang to her and she booked them for her own death.

Angela has fought breast cancer for over 25 years but now it has metastasised and she is currently receiving palliative care. A veteran, she can access a number of community supports, but at 64 years of age, has been facing significant barriers accessing supports through the NDIS or My Aged Care. When the Onkaparinga Compassionate Communities Collaborative launched in November 2022, Angela became a regular participant. People naturally warmed to her and were inspired by the ease with which she talked about her own death.

She wanted to attend a Death Café and actively participated when the local area hosted one in February 2023. It was touching to see the connections she established with another attendee, and they now catch-up and to talk about symptoms and service options available, but mostly just to enjoy each other's company and laugh.

Angela reflected that she would like her family to talk more freely about her death and better understand what palliative care means. She said, "We need to help the community understand that the word palliative is not scary. It doesn't mean that I am going to die in the next two weeks. But I do have a terminal illness and my palliative care team helps me to live each day to the full as well as prepare for death."

Visit: onkaparinga-compassionate-communities.mailchimpsites.com/

Contact: Gwyn Jolley, Secretary, Healthy Cities Onkaparinga - gwyn.jolley@outlook.com

GP Partners Australia

Project ECHO (Extension for Community Healthcare Outcomes) - Enhancing Palliative Care

About the project

Project ECHO – Enhancing Palliative Care was implemented by GP Partners Australia (GPPA) to deliver a model of medical education and case management to General Practitioners (GPs) in the SA statewide community.

The ECHO (Extension for Community Healthcare Outcomes) model™ provides GPs with the knowledge through online education seminars and supports them to better manage patients with complex conditions. In contrast to many traditional forms of teaching, ECHO training can adapt and respond to participants' needs.

This training approach enables GPs to access evidence-based, multidisciplinary advice for their patients facing a life-limiting condition or who are at the end of their life from a panel of experts, including specialist palliative care services physicians, pharmacists, palliative care nurse practitioners, social workers, education experts and allied health professionals.

Through teaching sessions and case presentations, participants have the opportunity to discuss cases which they have found challenging and determine the best course of treatment with experts in the field. GPs are able to review material from live sessions at a time of convenience to them through recordings shared on an online portal.

Nine 75-minute videoconferencing sessions were arranged at a time and frequency of most convenience to the participants (every four weeks at 6.30pm) using video/teleconferencing facilities in the hub (GP Partners Australia's teaching room), enabling participants to attend without having to leave their place of work or home.

To complement the live training sessions, a zone within The Palliative Hub – Learning Platform provided participant access to recorded sessions, handouts, and further resources.

The only requirement for GP participation was an internet connection and a device with a webcam. Participation was free for GPs and a total of 48 people registered for this Project ECHO series.

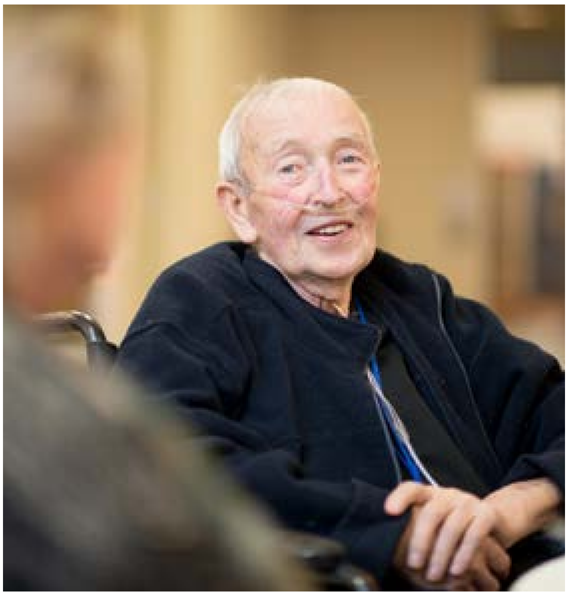
GPs described Project ECHO as contributing to their improved knowledge, skills, confidence, self-efficacy, and satisfaction. They reported the ECHO model as being an important tool for building connections within our health system and reducing their isolation, particularly for those GPs working in rural and remote areas.

What's next?

By continuously assessing, refining, and expanding ECHO sessions, a sustainable and effective learning platform for enhancing palliative care can be created.

Next steps in the ECHO model include:

1. Assessing the impact: An evaluation will be conducted to assess the impact of the ECHO sessions on GP knowledge, skills, and attitudes related to palliative care.
2. Expanding the reach: The ECHO model could be expanded by inviting more GPs from different locations or conducting sessions during a different time slot.
3. Focusing on specific topics: target content within palliative care that participants have identified as particularly important or challenging.
4. Creating a community of practice: A network for GPs could be developed to enable them to continue to connect, share knowledge and experiences, and support each other beyond the ECHO sessions.



Quotes

> *"The support and guidance provided by the Project ECHO team have been invaluable in my practice. I now feel more confident and better equipped to manage complex symptoms and provide end of life care to my patients and I now know who to call when I myself, need help"*
>
> **Project ECHO participant**

> *"I appreciate the ongoing learning opportunities and case-based discussions offered through the Project ECHO model. It has helped me stay up to date on the latest evidence-based practices and improve the quality of care I provide to my patients"*
>
> **Project ECHO participant**

Telling the story

A GP who has been providing care to patients in a rural SA area for several years joined the Project ECHO – Enhancing Palliative Care series and participated in virtual learning sessions focused on symptom management, communication, and end of life care planning. Through these sessions, they gained increased confidence, knowledge, and skills necessary to provide effective palliative care to their patients.

The GP applied what they had learned in Project ECHO sessions to manage their patients' symptoms effectively, provide emotional support, and involve family in care. They were also able to seek advice as required from a specialist palliative care physician, a subject matter expert participating in the sessions.

As a result of participating in Project ECHO, the GP reported feeling more confident and prepared in their ability to provide palliative care to patients. They were able to incorporate what they had learned and experienced into their practice and started to identify and manage symptoms more effectively. They also reported feeling more comfortable discussing end of life care planning with their patients and families, whilst knowing where to seek support from specialists.

Visit: www.gppaustralia.org.au/project-echo-enhancing-palliative-care/

Contact: Leanne March, GP Shared Care Programs Manager, GP Partners Australia
lmarch@gppaustralia.org.au

Flinders University

Experience of Unpaid Family Carers on Access to Palliative Care and Self-care Information, Resources, and Services

About the project

In 2019, the Australian Government implemented the Integrated Carer Support Service Model and introduced Carer Gateway to improve support services for carers. However, the extent to which these services are accessible and meet the needs of carers of people receiving palliative care is unknown.

This research project aimed to:

1. investigate the experience of unpaid carers for end of life and palliative patients on access to support services that assist them in their caregiving role, and
2. determine which services they access to maintain their own health and wellbeing.

As research partner and a provider of support services, Carers SA has advised on different stages of the project and assisted with the recruitment of participants.

A wide number of government and non-government organisations, professional and advocacy bodies, and health care services were approached to support the identification and recruitment of participants. These organisations included local councils, primary health networks, the Multicultural Community Council of SA, and over 300 metropolitan and regional general practices. The study was also promoted on radio, at death cafés, and at a carer's expo.

17 individual interviews and two focus groups were conducted with a diverse group of carers.

Preliminary findings were promising and provided new insights about the experience of carers navigating systems, looking after their own health, as well as how carers can be important collaborators in policy design and implementation.

Opportunities and gaps in the current model were identified and researchers have gained unique and interesting insights, particularly in relation to carer identification and recognition, the role of clinicians as gateways, difficulties in care navigation, death literacy, and informal support networks.

The researchers were able to build a strong and respectful collaboration with Carers SA, which will facilitate the dissemination of study findings with broader groups of carers, policy makers and practitioners to inform future policy and practice.

What's next?

Data collection still underway, and further opportunities will be identified to improve carer access to palliative care services and information, and also ways to encourage carers to seek help and support for their own wellbeing. Examples of strategies include peer supporting, carers training, and care navigation roles.

The potential role of a care navigator in general practice settings is an important finding to date. Researchers will continue to explore this role to assist patients and carers in understanding and accessing support services relevant to them.

Findings will be disseminated through academic journals and conference presentations, as well as shared in collaboration with Carers SA to ensure they reach broader stakeholders.

Quotes

"I think that education needs to happen with the GPs. If it wasn't for that lung nurse, that said to me, 'Hey, I think you need to talk to the doctor about palliative care', I wouldn't have even gone to my doctor to talk to her about it."

Carer

"I've felt Carers SA was very helpful. I think I did four coaching sessions, and they call it coaching, but it's really just having a chat. But again, it was just good to talk through things with someone. And the group setting, meeting with other carers, that was very, very helpful".

"The nurses were amazing. They were to go to. It was them. They're there only in the daytime, of course...The nurses were really good at knowing what I needed to know then."

Carer

Telling the story

*John** cared for his wife Mary*, who had brain cancer for over two years. After the diagnosis, Mary was relatively well for some time, but John also balanced his carer role with child care and work responsibilities. Later, when Mary became increasingly unwell, she needed to attend hospital every day for complex treatment. She later experienced a stroke from which she never recovered.

John remembers this time as incredibly exhausting. John had to decrease his working hours in order to take Mary to treatment and spend time with the kids. He didn't have a lot of time or energy to fill in paperwork or make phone calls to get the kind of support he needed as a carer. His initial applications for financial support were not successful.

John was put in touch with Carers SA and the Cancer Council who helped him quickly access more support at home.

John's experience shows the complexities and difficulties carers are faced with and he believes carers need more support to navigate the system.

**Not their real names*

Visit: www.flinders.edu.au/research-centre-palliative-care-death-dying

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Flinders University

Enhancing Dignity with Personal Care at the End-of-life in Residential Aged Care

About the project

Enhancing Dignity with Personal Care at the End-of-life in Residential Aged aims to identify factors that mediate dignity with intimate hygiene for residents with non-malignant end-of-life care needs living in SA residential aged care facilities. It also aims to identify aged care worker training needs and develop evidence-based resources about intimate hygiene for people at end-of-life.

Factors influencing staff capacity to conserve dignity when providing care with intimate hygiene include the following:

- Actively creating a positive team culture that challenges disrespectful communication styles that objectify residents. This includes purposefully modelling respectful behaviours.
- Awareness of the impact of environment on a resident's dignity. Continually working to ensure the area is like home, not a hospital (remove toilet rolls from bedside, shut door to bathroom)
- Impact of body language, touch, tone that can trigger or reduce challenging behaviours during receipt of care.
- Importance of engagement with residents with dementia in order to provide care.

Residential aged care sites have been identified to participate in the project and ethics approval has been received for a Clinician Photovoice Study and a Resident Photo Elicitation Study.

Learnings from interviews undertaken have highlighted that both verbal and non-verbal communication are important factors for dignity, conserving care for residents in aged care facilities. Attention to maintaining the personhood of the resident and respectful touch have also been identified as highly valuable.

What's next?

A focused recruitment drive will be held for clinicians and residents to participate in the studies. Educational videos are also planned to be filmed.

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Quick Contact Guide

Organisation and project	Name and position	Contact information
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South Australian Postgraduate Medical Education Association (SAPMEA) Supportive and Palliative Care for Dementia	**Helen Ho** General Manager	hho@sapmea.asn.au
RDNS Silverchain Early Identification of Clients at Risk of Deterioration or Dying with Non-malignant Disease	**Caroline Amato** Director Strategy SA	caroline.amato@rdns.org.au
Pharmaceutical Society of Australia Palliative Care Pharmacist Aboriginal Health Services	**Leah Robinson** Project Manager	leah.robinson@psa.org.au
Pharmaceutical Society of Australia Palliative Care Pharmacist Home Service in Regional SA	**Leah Robinson** Project Manager	leah.robinson@psa.org.au
Occupational Therapy Australia Palliative Care Webinar Series	**Michelle Oliver** Lead Mental Health Advisor	michelle.oliver@otaus.com.au
Motor Neurone Disease Association of South Australia (MNDSA) Talking Grief (Loss, Grief and Bereavement Volunteer Program)	**Kerry McMullan** Director Care Services	kmcmullan@mndsa.org.au
In Home Hospice Care In Home Hospice Care Mount Gambier	**Sandi Elliot** Hospice Manager	manager@ihhcare.org.au
Helping Hand Aged Care Palliative Care Holistic Leaders Program	**Kerry Catt** Advance Practice Consultant	kcatt@helpinghand.org.au
Healthy Cities Onkaparinga HCO Compassionate Communities	**Gwyn Jolley** Secretary, Healthy Cities Onkaparinga	gwyn.jolley@outlook.com
GP Partners Australia Project ECHO (Extension for Community Healthcare Outcomes) – Enhancing Palliative Care	**Leanne March** GP Shared Care Programs Manager	lmarch@gppaustralia.org.au
Flinders University Experience of Unpaid Family Carers on Access to Palliative Care and Self-care Information, Resources and Services	**Sara Javanparast** Senior Research Fellow	sara.javanparast@flinders.edu.au
Flinders University Enhancing Dignity with Personal Care at the End-of-Life in Residential Aged Care	**Deidre Morgan** Senior Lecture Palliative Care	deidre.morgan@flinders.edu.au

For more information

www.sahealth.sa.gov.au

Interpreter

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